Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, 2014	2014_189120_0011	T-510-13	Follow up

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

Long-Term Care Home/Foyer de soins de longue durée

THE GIBSON LONG TERM CARE CENTRE
1925 STEELES AVENUE EAST, NORTH YORK, ON, M2H-2H3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 10, 2014

An inspection was previously conducted on July 31, 2013 at which time non compliance related to bed safety was identified and issued as Order #007 on inspection report #2013-108110-0014 dated October 24, 2013. For this follow up inspection, the conditions set out in the Order have been met. See below for further details.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, nursing consultant and environmental consultant regarding the home's bed safety program.

During the course of the inspection, the inspector(s) randomly toured resident rooms and observed resident bed systems, observed the environmental consultant measure random beds for entrapment zones, reviewed the home's bed entrapment audit results, resident bed rail assessment results, resident's health records and staff attendance records for bed safety training.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. Where residents use bed rails, steps have not been taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On February 10, 2014, the Director of Care reported that 8 residents were using a therapeutic air surfaces and all 8 required the use of one or more bed rails. Two were actually observed sleeping on the surface with both rails in the raised position. No gap fillers or other space fillers were in place to minimize the entrapment zones. The Director of Care identified that neither resident was capable of moving independently in bed, that bed rails were being used by staff to reposition the resident only. However, the bed rails were left in the raised position by staff after they were used to reposition the resident. The Director of Care assumed that if the resident was not mobile, that leaving the rails in the raised position would not be an issue. However, residents on a therapeutic air mattress which runs on electricity to produce pressurized air cells may depressurize and inadvertently cause the resident to roll towards an area near the rail and become wedged. The plan of care for both residents identified the rails as a personal assistive services device to be applied when in bed. However, no other information was available that instructed staff to minimize any potential entrapment zones. Bed frames with therapeutic air mattresses in general are high risk for entrapment due to their compressible nature. For this reason, residents who use such mattresses are to be evaluated for specific rail type and frequency of use and the details included in their plan of care. Immediately after the inspection, four residents were re-evaluated and had their therapeutic air mattress replaced with a foam mattress which had been tested to pass any zone of entrapment for the bed models in the home.

Random bed systems were observed and re-tested throughout the home for entrapment zones. In particular, beds with 3/4 length rails (with black knob to release the latch) on Carroll frames were observed to have loose rails in two identified rooms. According to a personal support worker, at least one of the residents was using their bed rail for positioning. When the bed entrapment measuring tool was used by the home's environmental consultant, the tool slid down between the mattress and the bottom of the rail, failing a zone of entrapment known as zone 2. The beds were originally tested on January 3, 2014 and passed all zones of entrapment. However, after one month of use, the rails became loose and were not identified by staff. According to the maintenance person and administrator on February 18, 2014, the bolts were tightened on the beds and re-tested, passing zone 2 immediately after the inspection.
[s. 15(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where residents use bed rails, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment., to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 15. (1)	CO #007	2013_108110_0014	120

Issued on this 24th day of February, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

B Sosnik